

4369

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Calvert County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Beach</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Blyden</b> Last <b>Blyden</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/11/18</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	9. AGE (In years last birthday) <b>41</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <b>Jefferson Co., Kentucky</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Maurice Kirby Gordon</b>		14. MOTHER'S MAIDEN NAME <b>Mary Howard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Louis Blyden</b>		Address <b>North Beach Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of liver</b> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Two days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug. 1958</b> to <b>16 Apr. 1960</b> that I last saw the deceased alive on <b>16 Apr. 1960</b> and that death occurred at <b>12:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Huntingtown, Maryland</b> DATE SIGNED			
ACTUAL SIGNATURE <b>G. Weems</b> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>George J. Weems, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>4-19-60</b>	<b>Mount Carmel</b>	<b>Upper Marlboro Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hutchins Funeral Home Owings Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 21 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Wm. S. [illegible]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS  
CERTIFICATE OF DEATH

1921

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PROVIDENCE

4370

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Leonard</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Leonard</u> d. STREET ADDRESS <u>1 St. Leonard</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herbert</u> First <u>L</u> Middle <u>Howe</u> Last 4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>1960</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-19-1886</u> 9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>maryland</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>		13. FATHER'S NAME <u>William H. Howe</u> 14. MOTHER'S MAIDEN NAME <u>Carrie Gray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>218-16-3012</u> 17. INFORMANT <u>Archie Howe</u> Address <u>St. Leonard</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic arteriosclerosis</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1960</u> to <u>April 2, 1960</u> , that I last saw the deceased alive on <u>April 2, 1960</u> , and that death occurred at <u>6:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. E. Villarruel</u> M.D. <u>St. Leonard</u> ADDRESS (Street, city or town, State) <u>St. Leonard</u> DATE SIGNED <u>4/2/60</u>		PHYSICIAN'S NAME (Type) <u>R. E. VILLARUEL, M.D.</u>	
22a. (BURIAL) CREMATION, REMOVAL (Specify) <u>4-5-60</u> 22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Brooks Cem.</u> 22d. LOCATION (City, town, or county) (State) <u>Calvert co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u> ADDRESS <u>Prince Frederick</u> 24a. REC'D BY REGISTRAR <u>APR 7 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howe</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4371 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64320  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Anderson Janey</u> First Middle Last 4. DATE OF DEATH <u>4 24 1960</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan 26, 1928</u> 9. AGE (In years, last birthday) <u>32</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u> 11. BIRTHPLACE (State or foreign country) <u>Md</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>John Janey</u> 14. MOTHER'S MAIDEN NAME <u>Virginia Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. 17. INFORMANT <u>John Janey, Lusby</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gastro intestinal disease</u> <u>578X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Has been affected all life</u> (a), stating the underlying cause last. DUE TO (c) <u>due to birth injury</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) (County) (State) <u>Lusby</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H W Ward</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4/24/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-27-60</u> 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY <u>Brooks</u> 22d. LOCATION (City, town, or county) (State) <u>Mutual Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell, Prince Frederick</u> ADDRESS 24a. REC'D BY REGISTRAR <u>MAY 2 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



STATE OF NEW YORK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		HOURS	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
FINDINGS AT AUTOPSY		LABORATORY TESTS		HISTORICAL DATA		SOCIAL HISTORY		FAMILY HISTORY	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		HOURS	

## 4372 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Providence</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Owings</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harry V Lane</u>				4. DATE OF DEATH <u>4</u> Month <u>10</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/31/1871</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fletcher Lane</u>				14. MOTHER'S MAIDEN NAME <u>May Fowler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-36-8064</u>			
17. INFORMANT <u>Glin Lane Owings</u> Address <u>Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer &amp; arteriosclerotic disease</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>age</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov</u> 19 <u>59</u> , to <u>4/10/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/10</u> , 19 <u>60</u> , and that death occurred at <u>9:05 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. W. Ward</u>				ADDRESS (Street, city or town, state) <u>Owings Md</u> DATE SIGNED <u>4/10/60</u>			
PHYSICIAN'S NAME (Type) <u>H. W. Ward</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-13-60</u>		<u>Mt. Harmony Cem</u>		<u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home</u> ADDRESS <u>Owings Md</u>				24a. REC'D BY REGISTRAR DATE <u>APR 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# STATE OF NEW YORK DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

442X.



64322  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabnet</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Cabnet</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>?</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabnet County Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>CARRIE MAE LAUTSCH</u>		4. DATE OF DEATH <u>Apr. 13, 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 1, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William F. Bates</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Klotz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Fred W. Lautsch - Solomons, Ind.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 420.1 DUE TO <u>Generalized arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Admission of Thymoma</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. AGE AT DEATH <u>83</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year <u>Apr. 13, 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u>Solomons</u> (County) <u>Ind.</u> (State) <u>Ind.</u>	
21. I certify that I attended the deceased from <u>April 2, 1960</u> to <u>April 13, 1960</u> , that I last saw the deceased alive on <u>April 2, 1960</u> , and that death occurred at <u>Solomons, Ind.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>TR de Villarreal</u> M.D. <u>St. Thomas</u>		DATE SIGNED <u>4/13/60</u>	
PHYSICIAN'S NAME (Type) <u>TR de Villarreal M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 15, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Solomons Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Solomons - Cabnet Co - Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. A. Harrison &amp; Son - Mutual, Ind.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Priddy</u> DATE <u>APR 18 '60</u>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

420.1

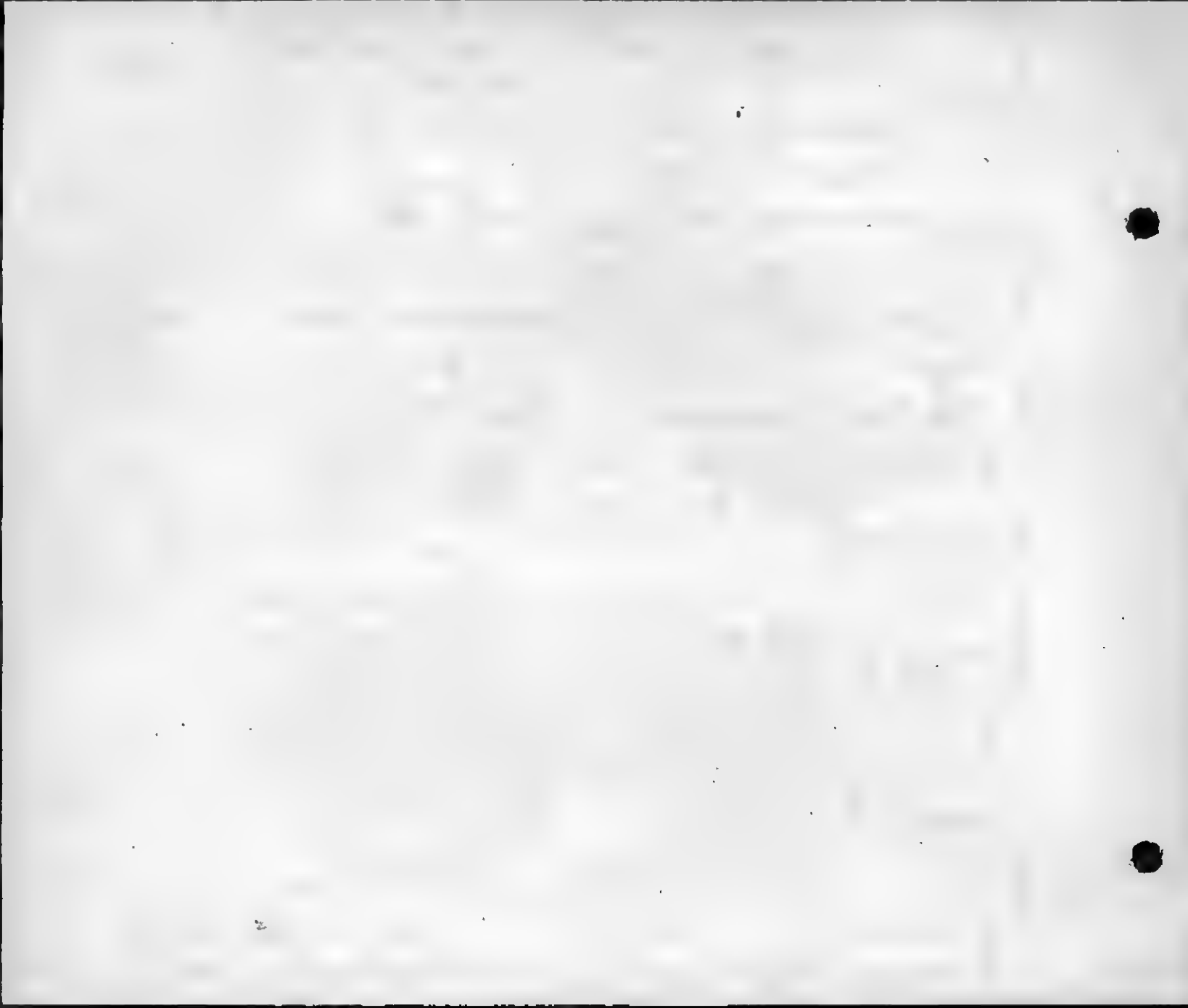
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any certificate is necessary, please execute it in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4374 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 1223

1. PLACE OF DEATH a. COUNTY <i>Adelbert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Kenn</i> b. COUNTY <i>...</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>...</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <i>469 S Pacific St</i>	
3. NAME OF DECEASED (Type or print) <i>Bruce</i> First Middle Last		4. DATE OF DEATH Month <i>4</i> Day <i>6</i> Year <i>1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>...</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/17/33</i> 9. AGE (in years last birthday) <i>27</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>factory worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bath, Md</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James Lee</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Oram</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>fractured 2 ribs in fall</i> DUE TO <i>with 2000 ft</i> Conditions, if any, which gave rise to immediate cause (b) <i>...</i> DUE TO <i>...</i> cause lost. (c) <i>...</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>...</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>...</i>	
20c. TIME OF INJURY Month, Day, Year, Hour a.m. <i>4/16</i> 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>...</i>		20f. (City or town) (County) (State) <i>...</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
SIGNATURE <i>H W ...</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>...</i>		DATE SIGNED <i>4/16/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Apr 20/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Bethel Hall Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Bethel Hall</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. ...</i>		24a. REG'D BY REGISTRAR <i>...</i> DATE <i>...</i>	
		24b. REGISTRAR'S SIGNATURE <i>...</i>	



4375

## CERTIFICATE OF DEATH

64325

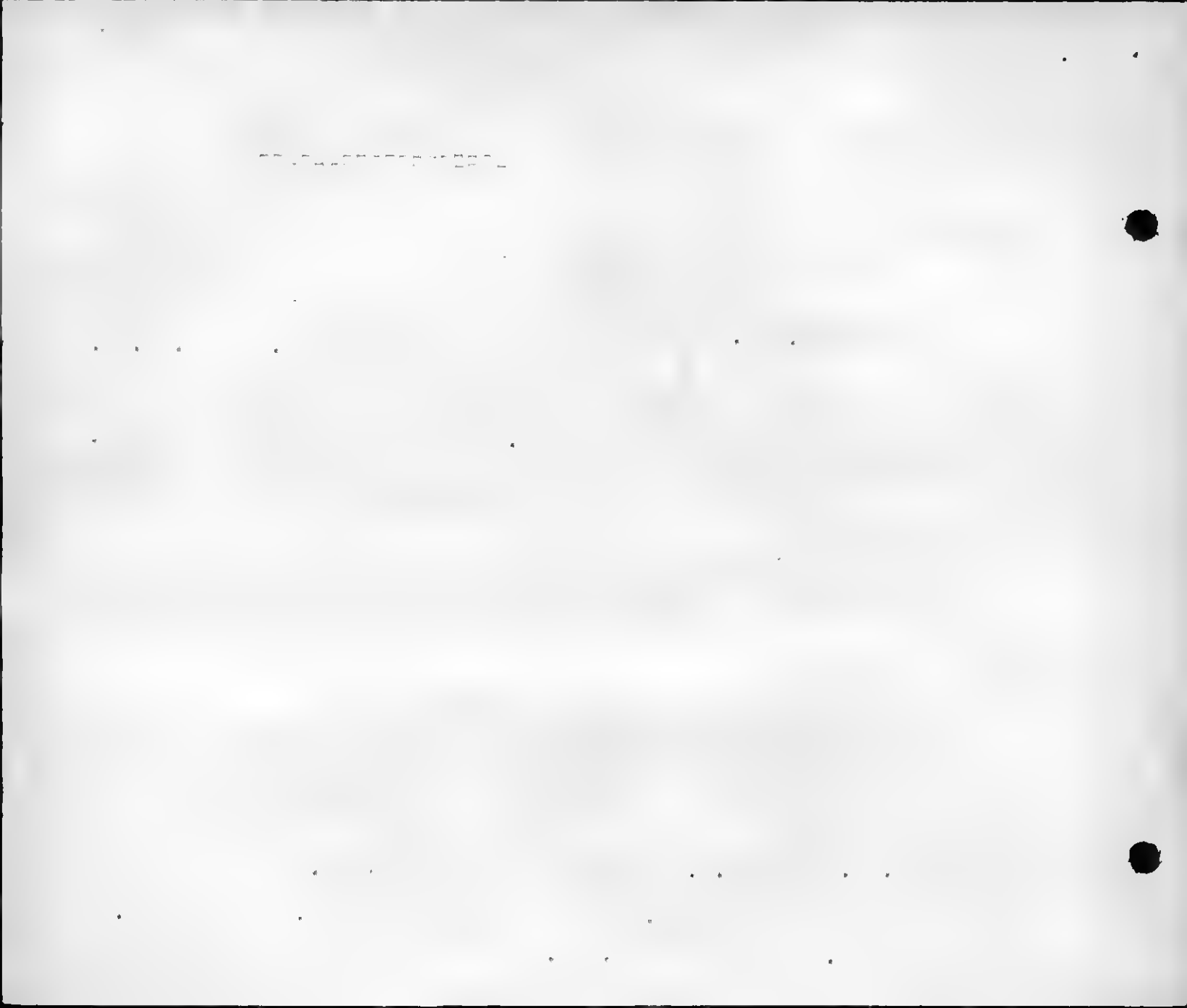
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE <u>MD</u> b COUNTY <u>St. J.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges</u>		c. LENGTH OF STAY IN 1b <u>1 Month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Chad &amp; Mary Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>David</u> First <u>Miller</u> Middle <u>Miller</u> Last		4. DATE OF DEATH <u>4</u> Month <u>1</u> Day <u>1960</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life. If retired, state so.) <u>Ins. Bus.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Abner Miller</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Stoner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Mrs. Etta Miller</u> Address <u>- Same as above.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prognosis made by several friends</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>3/24</u> , 19 <u>60</u> , to <u>4/1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/31</u> , 19 <u>60</u> , and that death occurred at <u>2:45 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, City or town, state) _____ DATE SIGNED <u>4/1/60</u>			
ACTUAL SIGNATURE <u>H W Ward</u> M.D. <u>Owings</u>			
PHYSICIAN'S NAME (Type) <u>H. W. Ward, M.D.</u> <u>Owings, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/4/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>	22d. LOCATION (City, town, or county) <u>Croom, Md.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u> ADDRESS _____		24a. REC'D BY REGISTRAR <u>DATE APR 18 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH

COUNTY **Calvert**

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN **Prince Frederick**

LENGTH OF STAY (in this place)

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE **Md.**COUNTY **Charles**

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN

**Waldorf**

HOSPITAL OR INSTITUTION OR STREET ADDRESS

**Calvert County Hospital**

STREET ADDRESS

(If rural give location)

## 3. NAME OF DECEASED (Type or Print)

(First)

(Middle)

(Last)

**Ethel****Perre**

## 4. DATE OF DEATH

(Month)

(Day)

(Year)

**April****11****19 60**

## 5. SEX

**Female**

## 6. COLOR OR RACE

**White**

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

**Widowed**

## 8. DATE OF BIRTH

**Jan 6, 1889**

## 9. AGE last birthday

**71** yrs.

## IF UNDER 1 YEAR

Months

Days

## IF UNDER 24 HRS.

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Housewife**

## 10b. KIND OF BUSINESS OR INDUSTRY

**Own Home**

## 11. BIRTHPLACE (State or foreign country)

**Pennsylvania**

## 12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

## 13. FATHER'S NAME

**John Treemellon**

## 14. MOTHER'S MAIDEN NAME

**Sophfrinia ?**

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)

**No**

(If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

**None**

## 17. INFORMANT &amp; ADDRESS

**Alfred Gregory, Waldorf, Maryland**

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**443 IMMEDIATE CAUSE**

(A)

**Cerebral Hemorrhage**

ARTICEDENT CAUSE(S) DUE TO

(B)

**Hypertensive C.V. Disease**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO

(C)

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## INTERVAL BETWEEN ONSET AND DEATH

**1 week**

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☐

## 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

## 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

## 21e. INJURY OCCURRED

While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

## 22. I hereby certify that I attended the deceased from April 7, 1960, to April 11, 1960, that I last saw the deceased alive on April 11, 1960, and that death occurred at 9:00 A.M. from the causes and on the date stated above.

## SIGNATURE

**James J. Jett**

M.D.

## ADDRESS (Street, city, town, state)

**Waldorf, Md.**

## DATE SIGNED

**4/11/60**

## 23. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

## DATE THEROF

**4-13-60**

## NAME OF CEMETERY OR CREMATORY

**Mt Rest**

## LOCATION (City, town, or county)

**La Plata, Maryland**

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

**Christina S. Kraus**

## 25. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

**The Hunt Funeral Home, Waldorf, Md.**DATE **APR 18 '60**

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4377

## CERTIFICATE OF DEATH

Reg. Dist. No.

04327

1. PLACE OF DEATH a. COUNTY <u>Calvert Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>C C St. M. V</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>5 yr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bertha Fumot Roper</u>		4. DATE OF DEATH <u>April 3 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 3. 1866</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Robertson</u>		14. MOTHER'S MAIDEN NAME <u>Mary Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mation Copps-Hollywood, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY ARTERY DISEASE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL ISCHEMIA + FAILURE</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1958</u> to <u>April 3, 1960</u> , that I last saw the deceased alive on <u>April 1 1960</u> , and that death occurred at <u>10a.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page C. Jett</u>		ADDRESS (Street, city or town, state) <u>Prince Frederick, Md</u>	
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>		DATE SIGNED <u>APR 8 '60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4-5-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>J. W. Lee</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. B. Robinson - Leonardtown</u>		24. REGISTRAR'S SIGNATURE <u>Arthur E. Harris</u>	





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FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																	
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY		Calvert		MARYLAND		b. STATE		Maryland		b. COUNTY		Calvert					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Prince Frederick		c. LENGTH OF STAY IN 1b		X		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Olivet		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Calvert County Hospital		d. STREET ADDRESS		1											
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year			
MATTHEW						SUTTON		April		8		19		60			
5. SEX		Male		6. COLOR OR RACE		Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		Jan 20, 1916		9. AGE (in years last birthday)		38 4/4 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Oysterman		10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		Maryland		12. CITIZEN OF WHAT COUNTRY?		U.S.A.			
13. FATHER'S NAME		John Cole		14. MOTHER'S MAIDEN NAME		Cora Sutton		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Beatrice Weems, Olivet, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Hypertensive Heart Disease.		443X		DUE TO		(b)		DUE TO		(c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Acute Alcoholism														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER		Charles S. Petty, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		4/9/60			
ACTUAL SIGNATURE		Charles S. Petty		EXAMINER'S NAME (Type)		Charles S. Petty, M.D.		Address (Street, city, town, or county)									
22a. (BURIAL, CREMATION, REMOVAL) (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country)		(State)									
Burial		4-12-60		Eastern		Olivet											
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE											
P.T. Sewell, Prince Fred,				DATE		APR 14 '60		Arthur S. Kraus									

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